Editorial

Hodgkin's lymphoma (HL) is a relatively rare malignancy, comprising of about 1% of all cancers and 30% of malignant lymphomas. Nevertheless, due to its exquisite responsiveness to radiation therapy (RT) and cytotoxic chemotherapy it has always attracted special attention from the oncologists. Although thought to be a prototype in management of malignancy with combined chemotherapy, the only other cancer in which such excellent outcome is matched are the germ cell tumours.

Epidemiological data show that HL has a biomodal age distribution, one peak in the young age (15-35 years) and the other in the older age (>50 years). However, the natural history of the disease and the outcome of management in both age groups appear to be different. In younger age group, this disease tends to remain localized for a long period and cure rate is extremely high. In elderly patients the disease usually presents with a more advanced stage and treatment outcome is also relatively poor. The international prognostic score show that elderly age itself is a poor risk factor.[1]

Hodgkin's and Reed-Sternberg cells (R-S cells) represent an expansion of a single clone originating from a germinal center B-cell with functional immunoglobulin gene arrangements but defective immunoglobulin transcription. For years there have been controversies regarding the origin of R-S cells. The current information show that in almost 98% of cases it arises from B-cells and in a very small number it could be of T-cell origin.[2]

In this issue, Parikh et from of the Gujarat Cancer Institute, Ahmedabad, report a retropective study of paediatric Hodgkin's lymhoma in a 10 year period.[3] The study mainly focuses on epidemiological aspect. This type of hospital - based epidemiological data is not a true reflection of incidence of any disease in a given area. Some may argue that HL being a rare disease, the patients are often referred to a major cancer center. This perhaps is a false notion. Although factual data are not available, currently many such patients in India are being treated in private practice as it is relatively easy to treat these patients with satisfactory outcome in majority. The present study is also most probably fraught with such flaws. There is very little doubt that national data should be collected meticulously and reported. I believe, ICMR has begun such an ambitious project recently. In spite of the inherent flaws in the data, the Gujarat center has shown male preponderance and increased incidence of mixed cellularity as reported by other authors from the developing countries.

Now that majority of young patients with HL become long-term survivors, the emphasis has shifted to prevent or minimize the toxicity that arise from chemotherapy and radiotherapy. Randomized trials have shown that 2-4 cycles of ABVD or only doxorubicin + vinblastine or 8 weeks of the Stanford V regimen followed by a lower dose RT can produce desired results. Although some oncologists in India have begun to manage early stage HL with this kind of approach, many continue to overtreat. Moreover, a proper interaction between medical oncologists and radiation oncologists in planning out the management is a rare event. In the current study also the frustration of the lead author is quite apparent. Even within a single institute in a short span of a single decade (last decade of twentieth century, when the ABVD regimen was established as a standard of care), the plethora of combination chemotherapy used in this cohort of patients is surprising. We do understand that the issue of economy comes to the fore in country like India.

Nevertheless, one expects a uniform institute-based treatment protocol in a well developed oncology center, specially for childhood HL. At the present time, no early stage young HL patient should die of this disease. If need arises, the authorities must develop programs to support all such patients.

Finally, I would like to call upon all young oncologists in the country (hopefully, they would bother to read this piece) to gather on a single platform and develop programs for hematologic malignancies. It is a tough call, but if India has to emerge as a force in the field of oncology, we must be able to unite. We have already lost a valuable time due to entirely avoidable reasons.

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